

# MEDICAL TREATMENT AUTHORIZATION

THIS REPORT IS TO BE COMPLETED IN ITS ENTIRETY BY THE EMPLOYER  
Fax or Email this completed form to FAS (972) 930-9479 or [CLAIMS@FASTPA.COM](mailto:CLAIMS@FASTPA.COM)

EMPLOYER INFORMATION: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ City: \_\_\_\_\_ State TX Zip: \_\_\_\_\_

PHONE: (\_\_\_\_\_) \_\_\_\_\_ FAX: (\_\_\_\_\_) \_\_\_\_\_ Policy# \_\_\_\_\_

INJURED EMPLOYEE: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

To: Approved Provider

The above referenced employee has reported sustaining an occupational injury/illness related to his or her employment. You are authorized to provide medically necessary treatment and/or prescription services for conditions related to the reported injury/illness.

Type of Injury \_\_\_\_\_

Your charges for medically necessary services will be paid directly by the Employer. To facilitate prompt payment, submit your billing document and a copy of the Report (physicians only) to:

**FAS**  
**P O BOX 2309**  
**Addison, Texas 75001**

Treatment and billing inquiries should be directed to *FAS, Inc.* at (866) 930-9493. For authorization to release medical records and other information relating to the above employee's occupational injury/illness, refer to Medical Records Release Authorization.

Drug /  Alcohol Screen Required  Yes  No

If the above box is checked **YES**, the employee is required to submit to a drug/alcohol screen which is only for the *initial* examination and emergency treatment of the injury noted above. Please conduct a drug/alcohol screen for your panel of controlled substances and alcohol, in addition to treating the occupational injury/illness. The results of the drug/alcohol screen must be reported only to the *Employer*.

\_\_\_\_\_  
Supervisor/Manager Name - Printed

X \_\_\_\_\_  
Supervisor/Manager Signature

\_\_\_\_\_  
Date